4/9/2004

State of Maryland Department of Budget and Management
Dental Plan Benefits RFP (HMO & PPO)
 # F10R4200129
Q&A Set #1

1. **On the D-PPO, do you want to see coverage level for out-of-network benefits (Ex. Preventive Services: 100% in network and 80% out-of-network)?**

   Answer: The plan design provisions shown in L-5 apply to both in-network and out-of-network services. The State is seeking a PPO program that does not provide incentive nor disincentive to use network dentists. However, if a Participant seeks services from network dentists, the cost of services will be discounted. Please note in the DPPO Deviations column on L-5 any deviations to the proposed plan.

2. **Does the deductible apply to ortho services or does it apply to Class II and III services only?**

   Answer: The deductible does not apply to orthodontic services. The deductible applies to Class II and III services only.

3. **In the RFI, in Section IV Dental Care Management/Quality Improvement(QI), for statements IV.6. & IV.7. i.e.**
   IV. 6. For denials, the dental plan sends enrollees and dentists written or electronic confirmation of the decisions within five working days of making the decision.
   IV. 7. The dental plan provides written confirmation of its decisions within two working days of providing notification of that decision, if the initial decision was not in writing.

   The question is: For the above two questions, do they relate to denials on pre-authorized treatment or the actual adjudication of the claim post treatment?"

   Answer: These questions refer to actual adjudication of the claims post-treatment.

4. **Regarding Attachment A, is this to be completed by Offerors, or is this for illustration purposes only? If it is to be completed by Offerors, what should be used for enrollment assumptions?**

   Answer: As stated in the first page of the "RFP Attachments A-N" file, Attachment A is for illustrative purposes only and is not required at proposal submission time. However, it must be completed, signed and returned to the

Procurement Officer by the recommended awardee upon notification as the recommended awardee. An Offeror must note any exceptions to the terms and conditions contained in Attachment A in the Executive Summary of their technical proposal.

5. **Section 1.1 states that "If an Offeror elects to propose services for both categories, the Offeror must submit separate complete proposals, one for each category." Section 1.18 then states "Neither multiple nor alternate proposals will be accepted. However Offerors are encouraged to submit proposals that include as many of the proposed plan designs as possible." Our question is, can an Offeror submit multiple PPO proposals based on the State's plan design using different PPO networks? Also, can an Offeror submit multiple DHMO proposals using different networks and different reimbursement methodology?**

   Answer: An Offeror can elect to submit proposals for both dental plan categories (PPO or HMO). However, an Offeror cannot submit multiple or alternate proposals for the same dental plan category. If an Offeror elects to propose services for both categories, the Offeror must submit separate complete proposals, one for each category. (See Addendum #1, Item #2)
   An Offeror cannot submit multiple PPO proposals based on the State's plan design using different PPO networks. An Offeror cannot submit multiple DHMO proposals using different networks and different reimbursement methodology.

6. **Attachment F – Information Technology Security Policy and Standards, includes a Standards Self-Assessment Checklist. Is this Attachment purely informational, or is the checklist to be completed by Offerors?**

   Answer: The Standards Self-Assessment Checklist in the Information Technology Security Policy and Standards is for informational purposes and is not to be completed by Offerors.

7. **DHMO Offerors typically have networks in major metropolitan areas and / or in multiple states, but none offer truly "national networks". Will Offerors who have only State of Maryland networks be considered?**

   Answer: Yes. A DHMO Offeror with a State of Maryland network only will be considered. See Section 5.2, Technical Criteria for the network criteria that will be applied to each Technical Proposal.

8. **The census we received from the State included all currently covered State employees. It did not include the entire population of State employees. Are we to bid on the entire population, and if so, how can we get a census for this entire population?**

Answer: The State will provide additional census information that represents greater than 95% of the State employee population. This information will be provided on a CD along with the dental census CD. Both are available through the Procurement Officer.

9. **Attachment L-9 states "If your response for a question is larger than 1,024 characters, please complete your response in Attachment L-4: Explanation using the directions provided in Attachment L-4". Does the character limit stated above include or exclude spaces?**

   Answer: Yes, the character limit does include spaces.

10. **Regarding MBE requirements, must Offerors only declare their intention to subcontract 0.5% to MBEs in the RFP, or must Offerors provide a list of MBE subcontractors they will use in the RFP? Does this requirement need to be met on an annual, quarterly, or monthly basis? Does the MBE business have to be based in Maryland?**

    Answer: The MBE goal for the DHMO and PPO plans has been changed to 1.0% of premiums paid. (see Addendum #1, Items #1, #3 and #4). Offerors must submit RFP Attachment D-1 with their technical proposal. By signing this document, Offerors agree to make a good faith effort to meet the State's MBE requirement and to solicit and negotiate with MBEs fairly throughout the RFP process. Offerors are not required to identify their MBE partners as part of their proposal, but may do so if they wish.
    The MBE participation goal is to be met over the entire term of the contract. However, contractors, as well as MBEs, are required to report payments made/received on a monthly basis (see Attachment D). This allows the State to track a contractor's progress toward meeting the goal.

    MBEs do not have to be based in Maryland. However, they must be MDOT certified in order to count towards meeting the MBE goal.

11. **Attachment D-2 is requesting copies of written solicitations to MBEs, descriptions of how the Offeror assisted the MBEs to fulfill or seek waiver of bonding requirements, etc. If it is <u>not</u> required that MBEs be listed in the RFP, how can this Attachment be completed prior to an Offeror selecting the MBEs that they will contract with?**

    Answer: Attachment D-2, D-3 and D-4 are to be completed by the successful Offeror after notification of award. These attachments are not to be submitted with the Offeror's proposal.

12. **The benefits requested for PPO under Attachment L-5 do not indicate "in" or "out" of network. Is the State looking for a passive plan design at the benefit level described?**

Answer: The plan design provisions shown in L-5 apply to both in-network and out-of-network services. The State is seeking a passive PPO program. Please also see Answer No. 1 above.

13. **When does the State expect a summary of the pre-proposal conference to be available, and must an Offeror acquire this summary via e-Maryland Marketplace, or are there alternative places to acquire this information?**

    Answer: The State expects to issue the minutes of the pre-proposal conference within three business days after the conference. These minutes will be available via e-Maryland Marketplace and the DBM website. These minutes will also be sent to all prospective Offerors who were sent this RFP or otherwise are known by the Procurement Officer to have obtained this RFP. The minutes will contain information for purchasing a transcript of the pre-proposal conference from the transcription company.

14. **Are DHMO plans required to coordinate benefits?**

    Answer: Yes, DHMO plans are required to coordinate benefits. Please Refer to RFP Attachment L 8, Compliance Checklist 59.

15. **What percentage of the eligible population resides outside the state of Maryland?**

    Answer: Less than 10% of the eligible population resides outside of the state of Maryland.

16. **Will State employees have the opportunity to change dental plans during the year, or only annually?**

    Answer: Enrollees in the State dental plans have the opportunity to change enrollment annual during the Open Enrollment period and during the course of the plan year if the enrollee experiences a change in status event for which mid-year changes in cafeteria plan elections are authorized under the IRS cafeteria plan regulations, if a HIPAA special enrollment period applies, or if other State or federal law provides a right for a change in enrollment. In addition, enrollees may be terminated from the dental plans if premiums are not paid or if certain eligibility requirements are not met.

17. **Please provide clarification on the age of eligible dependents and no student certificates required as of 1/1/2005. Does this mean that effective 1/1/05 the age changes from through 24 to through 23, with no cert required to prove student status?**

Answer: Yes – Effective 1/1/05 the age changes from through 24 to through 23, with no certification to prove student status.

18. **Please clarify the term "unique ID number" as used in the RFP. How many characters does this ID number contain, and are they alpha or numeric? Also, will these unique ID numbers be submitted in enrollment information or will they have to be assigned and cross-referenced?**

    Answer: Unique ID number is anything other than SSN. There are no limitation on the number of characters, numbers and alphabets contained in the unique ID number. No, the ID numbers will not be submitted in enrollment information. Plans are responsible for creating the unique ID numbers and cross-referencing the ID numbers to the enrollment information forwarded by the State.

19. **Have there been any plan design changes, vendor changes, or funding changes since January 2000? If so, please describe the changes that occurred.**

    Answer: No. There have been no changes since January 2000.

20. **Would the State consider a self-insured quotation?**

    Answer: No

21. **Can Offerors obtain the provider reimbursement schedules from the current vendors?**

    Answer: No. This is confidential information.

22. **What are the current rate relativities between tiers by vendor? (For example, Indiv. = 1.0, Employee + Spouse 2.0, Employee + Children = 1.7, Family 3.0)**

    Answer: For a summary of the State's current rates and benefits, go to website www.dbm.maryland.gov click on #9 under Most Popular Content – "2004 Medical and Dental Rates".

23. **Please provide further clarification regarding the use of the term "rate negotiations" referenced in question F-6 contained in Attachment M-2, which states "Offeror guarantees that the State will not be restricted in any rate negotiations by any federal or state mandates".**

    Answer: During rate negotiation every year, the dental plan contractor will be required to justify rate increases up to the maximum proposed rate for each plan year. The State expects the Offeror who is awarded a contract under this

solicitation to validate its rates for years 2005 through 2007, i.e. provide full documentation, calculations, and justification of how the rates were derived. If warranted, the premium rates will be reduced from those quoted in the Offeror's proposal. These rates may not be adjusted for laws or other regulatory requirements of the Offeror that do not affect the State's program. The contractor must agree that these rate negotiations will not be restricted or limited as a result of, for example, federal SSSG regulations.

24. Can copies of subscriber certificates which detail plan limitations, exclusions, etc. be obtained by Offerors?

Answer: Yes. These documents are available either by contacting the Procurement Officer who will make them available or by viewing on the DBM website and linking to the appropriate Benefit Providers.

25. Should Offerors assume that the PPO plan will cover the same procedure codes as currently covered by the UCCI POS plan?

Answer: Offerors should provide a quote for a PPO plan that will cover that which is mandated in the plan design as shown in Attachment L- 5.

26. Please provide information related to the timing of notifying finalists on the outcome of their bid, and also the estimated time when finalist presentations are to occur.

Answer: The estimated timeframe for discussions with offerors is 2 – 4 weeks after the proposal due date. Please see section 1.14-Oral Presentation. Offerors will be notified of the Procurement Officer's final recommendation for award sometime in late July (estimated). No contract award is final until all necessary State approvals, including approval by the Board of Public Works, have been obtained.

27. On the DHMO, you state that the Offeror should offer a comparable plan, in terms of covered services and member copayments. However, the copayments for the current plans can vary by 200-300%. For example, code 4210 (gingivectomy) is $45 in one plan and $125 in the other. Furthermore, with no rate increases in the past 4 years on these plans, what is considered a comparable fee?

Answer: Please provide your standard DHMO plan that is most comparable to the existing plans.

28. Several CDT codes have an asterisk (*) under the Member Pays column. What does the asterisk stand for?

Answer: The asterisk (*) indicates that the CDT code is not used by the current vendor on CDT code effective 1/1/2003 . Please see the reference to the asterisk above the Current DHMO Plan Design in Attachment L-5: Current and Proposed Plan Designs.

29. **Section 3 - Scope of Work, 3.1 indicates that the approximate enrollment is 77,500 enrolled. (UCCI DHMO - 33,917, UCCI POS - 26,020 and DBP DHMO - 17,586).**
The census data file shows UCCI - DHMO - 30,183, UCCI POS - 21,568 and DBP DHMO 13,785 - for a total of 65,536 enrolled. There appears to be a discrepancy of +/-10,000 enrollees.

    Answer: It appears that you have attempted to open the census data file using Excel. Access is the correct application software to use when opening the Census data files. Also, if you still have problems in Access, use a PC with both the "Read and Write" CD capability to insure that the Census data file opens.

April 21, 2004

State of Maryland Department of Budget and Management
Dental Plan Benefits RFP (HMO & PPO)
 # F10R4200129
Q&A Set #2

30. Section 1.18. Multiple or Alternative Proposals. In the past, the State has encouraged Offerors to suggest multiple, alternative plans within a single proposal. Please confirm that the State will not entertain such.

Answer: Please see RFP, Section 1.18, providing that neither multiple nor alternate proposals will be accepted. Offerors have three options. The State will accept one proposal for the DHMO or one proposal for the DPPO or one proposal for the DHMO and one proposal for the DPPO. The State will not accept multiple or alternate proposals for either category –DHMO and DPPO.

31. Section 3.2 Background. Will open enrollment be mandatory, where all State employees and retirees must elect new benefits?

Answer: The decision on a mandatory open enrollment has not yet been decided. All eligible State employees will have an opportunity to enroll in the DHMO or DPPO during open enrollment. Their enrollment will be effective January 1, 2005.

32. Section 3.2 Background. If the open enrollment is not mandatory, how will the current POS members be notified and handled? Will they automatically be moved into the new PPO option or must they make a selection of coverage?

Answer: See the Answer to Question 31 above. Also, during open enrollment, current POS members will have the choice to join the DHMO or DPPO or drop dental coverage effective January 1, 2005.

33. Section 4.4.4 Economic Benefit Factors. Where in the Technical Proposal would the State prefer that this discussion be included?

Answer: Please include your Economic Benefit response in a separate tab in your technical proposal after the Executive Summary.

34. Section 4.4.6.f Member Complaint Activity Report for 2003. Please clarify what the State is looking for and at what geographic level. Does the State want separate reports for the DHMO and the PPO? Does the State desire the total number of complaints, or is there additional information that the State would like?

Answer: The State would like to see the Offeror's standard member complaint report for 2003. As stated in Section 1.1 – If an Offeror elects to propose services for both categories, the Offeror must submit separate complete proposals, one for each category.

Therefore, the Offeror must submit separate Member Complaint Reports for the DHMO and DPPO. At a minimum, the Complaint Report should include a summary of the number and nature of complaints.

35. Attachment F – Information Technology Security Policy and Standards. Is this provided for informational purposes only or are Offerors expected to complete the assessment or comply with the policy?

Answer: Attachment F is for informational purposes. Offerors are not expected to complete the assessment. However, the Information Technology Security Policy and Standards is a broad policy that explains how the State will protect its IT and electronic data/resources. Offerors should know that State agencies have to comply with this policy. So, when the selected vendor(s) have to interact or communicate with DBM through electronic files, circuits, etc., they will be required to comply with this policy.

36. Attachment L-5 Current and Proposed Plan Designs. Would the State entertain a DHMO plan that allows members to go out of network if they wish?

Answer: The Proposed Plan Designs requested by the State are shown in Attachment L-5. The State is not interested in a DHMO plan that allows members to go out of network.

37. Attachment L-5 Current and Proposed Plan Designs. Is it the State's desire that child and adult orthodontic coverage be offered under the proposed DHMO and/or PPO plan designs? If the coverage is for dependent children only, what should we assume as the orthodontics age limit?

Answer: The Current and Proposed DHMO plan includes orthodontic coverage for children and adults. The Proposed DPPO Plan Design includes orthodontia for children only. Under the DPPO all eligible dependent children will be eligible for orthodontic coverage. Please see Section 3.1 Description of Current Program for further explanation of dependent eligibility.

38. Attachment L-5 Current and Proposed Plan Designs. Under the proposed PPO plan design, Class II services, does "periodontics" include surgical as well as non-surgical periodontics?

Answer: Yes, Class II services include all periodontial services.

39. Attachment L-6 Access: In the past, the State has required that the GeoAccess analyses be run with exact geocoding. Does the State have a preference as to which method is used: dispersion, centriod or exact?

Answer: The State does not have a preference on the method.

40. Attachment L-6 Access: GeoAccess analyses, DHMO and PPO. Providers frequently practice at multiple locations. Does the State want us to count a provider only once, regardless of how many locations the provider practices it, or does the State want us to count the access points (e.g.,the same provider at multiple locations)?

Answer: For the Geo-Access analyses, only count the access points.

41. Attachment L-6 Access: GeoAccess Analyses, DHMO. Some carriers have members select provider sites, rather than individual providers, as their primary care provider. Does the State want the GeoAccess reports to be for provider offices/sites for general dentists, or for unique providers practicing in an office? If the latter, should we count the provider only once, or count the provider multiple times if he/she practices in multiple locations for the purposes of the GeoAccess analysis?

Answer: For the Geo-Access analyses, only count the office/sites.

42. Attachment L-6 Access: Please confirm that the tables presented on this page are included only to show the layout of the GeoAccess reports that the State desires and that nothing should be filled in on this page.

Answer: Attachment L-6: DPPO, DHMO Access should be completed by the Offeror.

43. Attachment L-7 Dental Providers. Providers frequently practice at multiple locations. Both for DHMO and PPO, does the State want us to count a provider only once, regardless of how many locations the provider practices it, or does the State want us to count the access points (e.g.,the same provider at multiple locations).

Answer: We separately request the count of general/family dentists and general/family dentist locations. Only count individual providers once in response to the number of general/family dentists. We also only want locations counted once, regardless of how many individual providers use the location, in your response to the number of general/family dentist locations.

44. Attachment L-7 Dental Providers. Under DHMO plans, some carriers have members select provider sites, rather than individual providers, as their primary care provider. Does the State want the provider counts and GeoAccess reports to be for provider offices/sites for general dentists, or for unique providers practicing in an office. If the latter, should we count the provider only once, or count the provider multiple times if he/she practices in multiple locations?

Answer: Please see responses to Questions 40, 41 and 43 above.

45. Attachment L-8 CC.73. Please confirm that the State intends for out of network care under the PPO option to be reimbursed at the 80th percentile.

Answer: Yes, under the PPO option, the State intends for out-of-network providers to be reimbursed at the 80th percentile.

46. Attachment L-8 CC-10. Annual visits to network providers – does this question apply to both DHMO and PPO providers?

Answer: Attachment L-8 CC-10 pertains to converting data files. This Compliance Checklist item applies to both DHMO and DPPO plans. If you are referring to CC-102, the question applies to both DHMO and DPPO plans.

47. Attachment L-8 CC-103. Please clarify what is meant by "at-risk provider."

Answer: At risk providers are those providers that are at risk for terminating participation with the State's Dental program or the Offeror's Dental network.

48. Attachment M Financial Proposal. How much will the State be contributing toward the premium cost?

Answer: The State will maintain some form of employer contribution for the dental plans. However, it is not possible to say at this point what the contribution levels will be.

49. Attachment M Financial Proposal. Will the State's contribution be a flat percentage of premium regardless of tier, or will it be the same dollar amount regardless of tier?

Answer: The State will maintain some form of employer contribution for the dental plans. However, it is not possible to say at this point what the contribution levels will be.

50. Attachment M-4.a-b. Fully Insured Maximum Premium Rates. Is the State looking for one rate for three years, or three one-year rates?

Answer: The State will consider one rate for three years or three separate one-year rates.

51. You indicated that the asterisks on the current fee schedules indicated that that was probably not a listed item. However, on several of the items, they were just blank next to the fee. Does that mean that the current carriers do not cover that procedure at all? There were probably dozens of non-listed items, just blanks next to the fee.

Answer: The asterisk indicates that it is not a code within the current vendor's plan. The procedure itself may be covered under a different code. The blanks are for an Offeror to list additional services if such are part of the Offeror's standard DHMO plan, or the proposed DHMO plan.

52. On Attachment M6, how should the carrier respond if they have separate fee schedules for general dentists and specialists because some carriers don't have differences? It could be a big discrepancy.

Answer: Offerors should average the applicable fee schedules and provide a blended rate. If an averaged or blended rate is provided, the Offeror should include an explanation that corresponds to that response using Attachment M-3, the Explanation Worksheet.

53. I know for some of your other coverages, you have on-site representatives. That is not being requested here, right?

Answer: Correct. An on-site representative is not being requested as part of this RFP.

54. For Section 4.4.6 d), for which types of coverage would you like the certificate of insurance? There are a number of different insurance certificates and we're trying to figure out which type you're actually looking for.

Answer: Each insurance product offered in the State of Maryland must be approved and licensed by the Maryland Insurance Administration. Offerors should include that approval certificate as part of their proposals.

55. Does the State want a copy of the geo-access report we put together?

Answer: You should submit the Geo-Access report electronically. A hard-copy of the Geo-Access report should not be provided due to its length.

56. On the PPO plan, the coverage I had heard you say that you just wanted a passive PPO with discounted fees for in network versus out of network. Could we assume that's 180, 170, whatever we want it to be? Or is there some sort of defined criteria?

Answer: The criteria/Proposed DPPO Plan Design are shown in L5(the last page of L5). The schedule of benefits is the same whether a participant goes to a network dentist or to a non-network dentist for services. The cost of in-network services for a member and the State will be reduced based on the Offeror's negotiated provider financial arrangements. It is expected that the total cost for in-network services will be lower than the total cost for out-of-network services. Out-of-network services are to be reimbursed based on the 80^{th} percentile of R&C charges as required in L-8: Compliance Checklist, CC-73. The source of data for your R&C determination is not a requirement of the State.

57. There are two product categories, the DHMO and the DPPO. Is the DHMO defined by the scope in the schedule, or by the provider compensation methodology? In other words, could you use just a discounted fee for service schedule as opposed to paying capitation?
Again. The question is for the DHMO, and you have stipulated there are no alternative plan designs. But if you use the exact co-payment schedule, just pay fee for service, would that work, as opposed to paying capitation on a certain subset of procedures?

Answer: The DHMO plan will provide a network only, fixed member co-payment schedule of benefits. The Offeror establishes the method of provider compensation and may elect to use capitation, discounted fee-for-service or any other method of provider compensation.

58. In today's terms, the 80th percentile is pretty vague. Can you tie that to a specific schedule that you want 80th percentile paid on? We want to find out what schedule 80th percentile refers to.

Answer: The 80th percentile may be derived very differently from vendor to vendor. The State is not requiring that a specific data source or schedule be used, only that regardless of the data source or schedule an Offeror regularly uses in its DPPO plan, the Offeror pay out-of-network dentists at the 80th percentile point. Each Offeror's proposal should disclose the data source or schedule to be used in the Offeror's proposed DPPO plan.

59. I know you indicated clearly that one DHMO proposal should be submitted, and one PPO proposal will be submitted. But looking at Section 1.18, I note it states offerors are encouraged to submit proposals that include as many of the proposed plan designs as possible. I'm trying to interpret if the company has multiple PPO networks and you can do the exact plan design with different networks and submit as many proposals as possible. That is certainly different in saying only one per plan design.

Answer: The State's required plan design is described in Attachment L-5. Offerors must submit a proposal that is as comparable as possible to the plan design described in Attachment L-5. (See Addendum #1, Item #2.)

60. A question on the 109 benefit fairs. Do they tend to be lumped together, four in one day? Or is it spread out? As we try to figure out costs of coverage.

Answer: Benefit fairs are generally scheduled on a regional basis. A copy of last year's schedule of benefit fairs is attached to the email transmitting this Q&A Set #2. **Please note: There is no guarantee that this year's schedule will approximate last year's schedule.**

61. A quick question to clarify the financial portion. My understanding is that you want a separate package for each of the DHMO/PPO. Within those packages, there is a Section M5A and an M5B that ask for rates for each of those plans.
So within the DHMO financial packet, you would be requesting rate information for a PPO?

Answer: No, that's not correct. Each PPO financial submission must include only the information requested in Attachments M-1 through M-8 for the PPO proposal. Each Attachment specifically identifies whether it is necessary for the DHMO submission or the DPPO submission.

62. For the provider analysis, you were saying that you are looking for a single provider count and a facility account. So for the first one, I would assume if I had one provider that has three locations, that provider is only counted once.
But for the second count, if I have five providers in one location, that location is only counted once? Is that correct?

Answer: Yes

63. Can you provide us with a historical price for the last couple of years for the printing and marketing of the resource guide?

Answer: The average cost *per plan* for the Open Enrollment booklet issued in Fall 2003 was approximately $13,000. There were 11 plans described in that booklet.

64. Does the state apply the premium tax?

Answer: Premium taxes are owed to the Maryland Insurance Administration in accordance with Maryland Annotated Code, Insurance Article Title 6, Subtitle 1 and Code of Maryland Regulations, Title 31, Subtitle 6. Dental plans are generally subject to these taxation requirements unless the specific plan is exempted from taxation pursuant to Md. Ann. Code, Ins. Art. 6-101. For example, health maintenance organizations authorized by Title 19, Subtitle 7 of the Health-General Article are exempt from payment of the premium tax. Each Contractor is responsible for fulfilling its obligations and responsibilities to the Maryland Insurance Administration, including the payment of taxes and filing of related tax reports where applicable.

65. You stated earlier no multiple proposals. Suppose that you encouraged an MBE as a PPA arrangement, but then we are also bidding separately. Would that count as multiples? Is it defined by vendor? Or is it defined by legal entity? Say you were pairing up with another company from an ASO arrangement, so you were doing the administration for another entity, but also wanted to bid on your own. Would that count as multiple, it is the same administrator, but it is two separate companies that would technically be bidding. Let's say we're providing the administration network for another company. That company was bidding. So

we're still administrating under two different entities, but it is the same administrator.

Answer: The legal entity that submits a proposal determines whether or not a proposal is a multiple proposal. Each individual Offeror may submit only one proposal per category. Please refer to Question #30. The State will accept only one proposal per entity. An entity or organization that is a subcontractor for another entity's proposal (i.e. another Offeror's proposal) may also submit a proposal on its own as an Offeror. Therefore, if Company A uses Company B as a subcontractor for providing the services requested in this RFP, Company B may also submit a proposal of its own..

66. Under the performance guarantee section, could you just please clarify for guarantees eight, nine and ten, the liquidated damages column? It says, remedial action plan provided to and approved by the state.

Answer: There is no financial remedy applicable for those guarantees but the Contractor must provide an explanation of the deficient performance and an action plan for achieving the guaranteed performance level. Please note that the Contract, Section 4.3 authorizes the Procurement Officer to withhold or limit payment in the event of untimely or unsatisfactory performance.

67. I know the asterisk indicated codes are not used by current vendor, and I'm trying to clarify that when there are codes that are ADA codes and they are not used, does that mean the member pays 100 percent of that fee in full out of pocket? Because if they go to a dentist who participates and those codes are not used, then they don't cover it. You either cover it or you don't cover it. I'm not sure what codes are not used means on those procedures.

Answer: We believe that when the transition to CDT4 occurred, which was not complete at the time of the State's open enrollment purposes when this list was developed, not all of the conversion was completed. As a result, the codes for some procedures had not be completely cross-walked and there are two sets of codes. It is the State's intent to procure a DHMO that has coverage of the services listed in the plan design, but coded under the CDT4 coding.

68. Will the state employees have the opportunity to change dental plans during the year? Or just once a year annually?

Answer: Enrollees in the State dental plans have the opportunity to change enrollment annual during the Open Enrollment period and during the course of the plan year if the enrollee experiences a change in status event for which mid-year changes in cafeteria plan elections are authorized under the IRS cafeteria plan regulations, if a HIPAA special enrollment period applies, or if other State or federal law provides a right for a change in enrollment. In addition, enrollees may be terminated from the dental plans if premiums are not paid or if certain eligibility requirements are not met.

69. In your RFP, you state that you request a claim form that has a State of Maryland logo on it. Do you have an existing claim form that you're asking that we use?

Answer: There is no requirement to use an existing claim form; however, any claims forms used by the Contractor in administering the State plan should include the State logo.

April 21, 2004

State of Maryland Department of Budget and Management
Dental Plan Benefits RFP (HMO & PPO)
 # F10R4200129

Q&A Set #3

70. Three-year rate commitments from a carrier without enrollment or contribution commitments from the plan sponsor are very rare, as are fixed rate methodology for years four and five. If caveats are included in a proposal, how will the State respond (i.e. The proposal is automatically disqualified, the State will negotiate at the finalist meeting time frame, the State will/may accept in the final language)?

Answer: The State, by law, cannot accept a financial offer from a vendor that makes the offer contingent on any other factors. We are asking for dental plan coverage for which costs are much more predictable than medical plans. If the offeror includes contingencies as part of their financial offer, the offeror will be asked to remove them. If the offeror is not willing to remove the contingencies, the offeror's proposal will be removed from further consideration.

71. The contract requires broad indemnification from the carrier relating to performance, without any reciprocal indemnification by the state for wrongdoing. Are reciprocal arrangements in place with any carrier currently, and would the State consider such language?

Answer: There are no arrangements under the current contracts for indemnification by the State. Nor will the State consider reciprocal indemnification as part of the upcoming contracts.

72. Are MBE evaluation points based on an all or nothing scoring methodology?

Answer: There is no scoring methodology, as described, that will be used to evaluate offerors' proposals. The offeror's technical proposal must include a completed copy of MBE Attachment D-1. If Attachment D-1 is not submitted with the technical proposal, and the offeror makes it known to the State that they are not willing to make a good faith effort to meet the MBE requirement, the offeror will be eliminated from consideration at that point.

73. Has the State ever held premiums owed a carrier due to service issues?

Answer: The State has never withheld premium payments on outstanding invoices because of service issues. However, the State has separately assessed and collected liquidated damages in connection with a contractor's failure to meet specific performance guarantees outlined in the contract. However, please note that the Contract, in Section

4.3, authorizes the Procurement Officer to withhold or limit payment due to untimely or unsatisfactory performance.

74. DHMO experience is not always provided by carriers, as this is usually considered proprietary. If DHMO experience is provided to the State, would you consider signing a confidentiality agreement?

Answer: RFP Attachment A (sample contract), Section 7.0 and Maryland State Government Article, §10-617(d), provide contractors with significant protection with regard to the release of confidential information. Under §10-617(d), the State is prohibited from disclosing information that is confidential commercial information. If you have additional specific provisions that you believe is necessary to have in place prior to releasing the requested information, those additional provisions should be identified in the Executive Summary of your technical proposal. However, there is no guarantee that the State will not request that such proposed provisions be removed as an unacceptable exception.

75. What is the main purpose for the bid?

Answer: The purpose is to procure dental benefit services and maintain uninterrupted dental benefit services for State employees, retirees and their dependents. The current contracts expire on 12/31/04. Please also see the RFP Section 1.1.

76. Is there a requirement for the State of Maryland's Dental plan to be bid within a certain number of years?

Answer: No. There is no such requirement. However, please note that the contracts that result from this procurement shall be for the term specified in the RFP, Section 1.5.

77. How long have the current DPPO and DHMO carriers been offered to the State of Maryland's employees?

Answer: The current DPOS and DHMO plans and carriers have been offered to the State of Maryland employees since January 2000.

78. Would you consider an alternative to the current/requested DHMO plans whereby a Dental PPO plan with copays on the in-network portion of the plan and relatively weak coinsurance on the out-of-network portion of the plan is offered in lieu of one or both of the DHMO plan options?

Answer: At this time the State will not consider a dental PPO in place of the proposed DHMO.

79. Regarding the funding arrangement, the financial exhibits in attachment M refer to Fully Insured Maximum Premium Rates. By Maximum Premium Rates, are you referring to a minimum premium approach, or are you

requesting a normal fully insured (non-participating) approach with Maximum meaning that no premiums would be due other than those attributable to the fully insured rates (i.e. no deficits, no Retrospective Premium call, no bank account for claim funding, etc.)?

Answer: We are requesting a normal fully-insured (non-participating) approach as described in Attachment M-1, Instruction #3.

80. Currently, the dental coverage is 50% employer paid for employees and dependents. To have comfort in setting expected claims and rates, can you please provide:

a) What were the employer contributions for employees and dependents for 2001, 2002 and 2003?

b) Do you plan to keep employer contributions at 50% for employees and dependents in 2005, or do you expect that contributions will change?

Answer: a) The employer contributions were at 50% starting in 2000 and have remained so through the current and last contract year.
b)The State will maintain some form of employer contribution for the dental plans. However, it is not possible to say at this point what the contribution levels will be.

81. What dental plan design changes, if any, have occurred since 2001?

Answer: There have been no dental plan design changes since 2001.

82. We noticed on the experience reports that the enrollment for one of the DHMOs and for the DPPO plan have been increasing over the past few years. What is the reason for the increase in enrollment over the past few years?

Answer: Since the 2000 contract year, increases in enrollment have occurred mainly due to the State's 50% premium subsidy. Beyond that, it is difficult to say what underlies shifts in enrollment from one year to the next.

83. Starting in 2002, the PPO claims are broken out between capitation and paid claims. Why would capitations be reported for the PPO plan? What exactly do the capitation amounts represent?

Answer: Attachment J-6: UCCI DPOS Claims and Enrollment includes capitation and paid claims for the DPOS plan not a PPO plan.

84. We will be happy to complete a Confidentiality Agreement. In exchange, can you please provide a census with zip codes, gender and date of birth?

Answer: Both census CDs (one for enrolled dental population and the other for all potential enrollees) are currently available to vendors through the Procurement Officer upon completion of the Confidentiality Agreement (Attachment E).

85. The "2004 Health Benefits Booklet for Current Employees" on www.dbm.maryland.gov does not provide much detail on the current PPO plan design (we were not able to find coinsurance levels for services other than Preventative & Diagnostic). Can you please provide additional details on covered services at each coinsurance level, frequency limitations, exclusions, and basis for out-of-network reimbursement, etc? A full plan booklet would be preferable in order for us to provide an insured quotation.

Answer: The State is not currently offering a DPPO. If you are referring to plan documents for the current DPOS and DHMO plans, please see the answer to question #24 issued to offerors on April 9th.

86. The "2004 Health Benefits Booklet for Current Employees" on www.dbm.maryland.gov mentions that ortho is covered in-network only. For contractual filing reasons, our quoted plan would either need to include ortho in-network and out-of-network, or exclude ortho altogether. As a result, will you approve of a proposed DPPO plan that includes coverage for ortho on both the in-network and out-of-network portions of the plan?

Answer: The orthodontic benefit in the newly proposed PPO Plan Design is as outlined in Attachment L-5: "Current and Proposed Plan Designs". The PPO orthodontic benefit is the same for in-network and out-of network.

87. The "2004 Medical and Dental Rates" on www.dbm.maryland.gov lists biweekly rates and monthly rates, where the monthly rates = 2X the biweekly rates. Typically, biweekly rates would equate to 26 deductions per year, but since the monthly rates are 2X the biweekly rates listed, are the biweekly rates really taken only 24 times per year?

Answer: The bi-weekly rates are taken 24 times/year.

88. **Given that our Dental plan does not rely on ID cards in order for employees/members to access care, is it acceptable for us to proceed on the basis that we will not be generating Dental ID cards?**

Answer: Please see Attachment L-8: Compliance Checklist, CC-16. All "No" responses to Attachment L-8 must be addressed in the explanation document (Attachment L-4).

89. Is monthly premium data available to coincide with the previously provided claims and enrollment data in Attachment J?

Answer: The monthly premium data paid each month that coincides with the previously provided claims and enrollment data in Attachment J-6 is available and is provided in Addendum #2 Item #3.

90. Please confirm the desired Out of Network UCR level for DPPO. A review of the current DPOS benefits reveals Out of Network payments well below typical UCR levels.

Answer: Under the DPPO option, the State intends for out-of-network providers to be reimbursed at the 80th percentile (See Attachment L-8: Compliance Checklist, CC-73).

91. Please explain the reasons for marketing the dental program at this time. (Current contract expiration, cost concerns, administrative concerns, network concerns, etc.).

See answer #75 above.

92. The current plan utilizes a PPO network. What is the current in-network utilization for claims-paid both in terms of dollars and number of claims?

Answer: The State does not currently offer a DPPO. Rather, a DPOS plan is one of the options offered. The in-network utilization for this DPOS plan is approximately 75% based on claims dollars. Utilization based on numbers of claims is not available.

93. Please provide the current rates for each plan now being offered.

Answer: Rates for 2004 are posted on website www.dbm.maryland.gov

94. Are there any separate network access fees now being paid as part of the current contracts?

Answer: There are no separate access fees being paid as part of the current contracts. The current contractors receive only premiums for the DHMO and DPOS plans.

95. There is a significant minority business target included as part of the RFP. We consider our network providers to be are our business partners. Can the dollars paid to minority network providers be counted toward the minority participation goal?

Answer: If your minority network providers are certified through the Maryland Department of Transportation, payments to those providers will count towards meeting your minority participation goal.
Also, Offerors should note that payments made by prime contractors to MBEs for services and/or products that are not directly related to the State of Maryland contract will be prorated based on the contractor's total book of business, unless the contractor provides documentation that the services/products purchased are directly attributable to

the State's contract, e.g., staffing for benefit fairs, etc. For further explanation, please see the sample MBE payment calculation which is attached to the email that transmits this Q&A #3.

96. The performance guarantees require 100 percent attendance by the dental benefits provider at open enrollment meetings. Would the state consider a minimum attendance level by Maryland employees as part of the guarantee? This would guard against incurring excessive costs to attend meetings that have low or minimum attendance.

Answer: The State will not guarantee a minimum employee attendance level for open enrollment meetings.

97. In the Financial Proposal Section, page #5, please define in financial terms the meaning of "Fully Insured Maximum Premium Rates."

Answer: The "Fully Insured Maximum Premium Rates" are the firm monthly premiums the Offeror quotes on a fully-loaded basis described in Attachment M-1, Instruction #3.

98. Please explain the rating method now in place for each dental plan offered. Are they fully insured, minimum premium arrangements, etc?

Answer: The current dental plans are fully insured.

99. Please confirm at what fee level percentile of reimbursement the current out-of-network claims are being paid under the PPO program.

Answer: The State does not currently offer a DPPO. Rather, a DPOS plan is one of the options offered. The fee level reimbursement for out-of-network claims is not available. There have not been changes to the current schedule since 2000.

100. Please confirm that employee premium contribution is 50 percent for both the PPO and DHMO offerings.

Answer: Under the current contracts, the State provides a subsidy at 50% of premium rates. The State is not able to confirm the same 50% subsidy levels for the contracts resulting from these RFPs. However, some level of subsidy will be provided.

101. Is it the State's intent to pay out-of-network claims at the 80th percentile so that out-of-network claims are paid at a higher amount than in-network claims?

Answer: For the DPPO, out-of-network claims will be reimbursed at the 80th percentile. Please refer to Attachment L-8: Compliance Checklist, CC-73. In-network claims are expected to be paid based on the Offeror's negotiated provider arrangements.

102. Can you please share with us the case structure that is currently utilized by the State of Maryland so we can review to understand the level of complexity? The case structure will also help us to identify if we will be able to comply with the reporting requirements outlined in Attachments J-1b and J-1c.

Answer: It is expected that eligibility data to be used in developing Attachment J-1b: Membership Analysis and Attachment J-1c: DPPO Network Utilization will include a subgroup field identifying Actives, Direct Pay, Satellites and Retirees.

103. If the current case structure does not include separations for each county (in addition to Actives, Direct Pay, Satellites and Retirees), would it be acceptable for us to break out the case structure separately by county for reporting purposes so we can meet the reporting requirements outlined in Attachment J-1c? As a point of clarification, the State of Maryland would need to provide eligibility information to us as per the case structure.

Answer: The State will provide the selected vendor with eligibility data that includes subgroup and zip code of the participant. It will be acceptable for the vendor to additionally separate by county for the reporting requirements outlined in J-1c: DPPO Network Utilization.

104. In section 1.18, please clarify what the State considers multiple proposals. (Example: same legal entity or same administrator).

Answer: If the State receives more than one proposal from a vendor who is, for all intents and purposes, the same legal entity, the State will consider this to be a multiple proposal submission, which is not allowable under this RFP.

105. Can the State please clarify the definition of a DHMO? Is it defined by a fixed co-payment schedule, or the method of provider compensation (i.e. capitation)?

Answer: The DHMO plan will provide a network only, fixed member co-payment schedule of benefits. The Offeror establishes the method of provider compensation.

106. Will the State consider allowing alternate product proposals that maintain the State's goals of access, cost containment and customer service?

Answer: An Offeror may elect to submit one proposal for each dental plan category (DPPO and DHMO). However, an Offeror may not submit multiple or alternate proposals for the same plan category.

107. Does the State plan to maintain a 50% employer contribution on <u>all</u> plans for 2005?

Answer: The State plans to maintain some level of employer contribution. However, we cannot provide the specific levels at this time (see answer #100 above)

108. In order to evaluate of the current out-of-network (OON) claims experience on the POS, please confirm whether the claims are paid at the 80th percentile of UCR or off a maximum allowable charge (MAC) schedule. If the OON claims are paid off a MAC schedule, can you please provide the schedule?

Answer: The fee level reimbursement percentile for out-of-network claims is not available. There have not been changes to the current schedule since 2000.

109. Please confirm that OON claims on the proposed DPPO will be at the 80th percentile of UCR.

Answer: For the DPPO option, the State intends for out-of-network providers to be reimbursed at the 80th percentile (See Attachment L-8: Compliance Checklist, CC-73).

110. To better accommodate the small group of Puerto Rican employees detailed in the census, can an Indemnity plan be offered to this population?

Answer: From the census we have on file, there are 4 employees in zip codes 006 to 009, which cover Puerto Rico. The DPPO plan would adequately cover this group, even at out-of-network reimbursement levels.

111. What is the percentage of in-network claims (# & $) on the current POS plan?

Answer: The in-network utilization for the DPOS plan is approximately 75% based on claims dollars. Utilization based on numbers of claims is not available.

112. What is the percentage of membership that utilized an out-of-network provider under the current POS plan?

Answer: These data are not available.

113. Please define "category" on CC-51 in the PPO proposal. Is "category" synonymous with "subgroups" identified in Section J or does "category" refer to Class I, II, III and IV services?

Answer: In Attachment L-8: Compliance Checklist, CC-51, “category” refers to the two types of programs the State will offer employees in 2005, DHMO and DPPO.

114. Do the reports noted in L-8, CC-76 & 77 in the PPO proposal refer to those outlined in Attachment J? If no, please explain.

Answer: See Dental RFP Addendum # 1 issued on April 9, 2004.

115. Please clarify that there are no monthly report request, only Quarterly reports sorted by month.

Answer: Yes. The State has no requirements for submitting Dental Program reports on a monthly basis. The required quarterly reports should include monthly data as described in Attachment L-8: Compliance Checklist, CC-76.

116. From the pre-bid conference, we understand that the Technical Responses will be considered first to ensure that each carrier can meet the Technical Requirements of the State, and then Financial Responses will be reviewed afterward for those carriers meeting the Technical Standards. However, we are interested to know if there is a specific grading/weighting scale that will be used in your analysis of the proposal responses. Your efforts in sharing details on how much weight will be placed on various components of the proposal responses will be very helpful in directing us to place the greatest emphasis on the areas of most importance to the State.

Answer: With regard to the technical proposal submission, offerors should pay special attention to Sections 5.2 and 5.3 of the RFP. Section 5.2 lists the evaluation criteria in descending order of importance, i.e., Criteria #1 is most important to the State, Criteria #2 is second in importance, etc. There are no numerical weighting/scoring mechanisms that will be used to evaluate proposals. In making an overall determination as to which offeror has presented the most advantageous offer to the State, technical considerations will be more important than financial factors.

117. We went onto the State website and accessed the SPDs that are available separately for Actives and Retirees. In reviewing these SPDs, we noticed that many plan details are not specified (i.e. frequency limitations, late entrant provisions, etc.). As a result, your efforts in sharing with us the actual certificate booklets/contracts that exist with UCCI and DBP will allow us to have the level of plan design details necessary to underwrite and price the proposed Dental plans for the State effectively.

Answer: See answer #85.

118. The SPD indicates maximum reimbursements that are allowable on the out-of-network portion of the DPOS plan with UCCI. For how long has this out-of-network schedule been in place and how frequently is it updated? If it has changed historically, can you please provide the schedules that have existed historically to correspond to the years for which we have claims history, 2000 through 2003?

Answer: The current DPOS schedule of benefits has been in place since 2000.

119. For how long has the in-network copay schedule been in place on the DPOS plan with UCCI and how frequently is it updated? If it has changed historically,

can you please provide the schedules that have existed historically to correspond to the years for which we have claims history, 2000 through 2003?

Answer: The current DPOS in-network co-payment schedule has been in place since 2000.

120. For how long have the copay schedules been in place on the DHMO plans with DBP and UCCI and how frequently are they updated? If they have changed historically, can you please provide the schedules that have existed historically to correspond to the years for which we have claims history, 2000 through 2003?

Answer: The current DHMO co-payment schedule has been in place since 2000.

121. Does the bid affidavit have to be signed by the resident agent, or can an authorized agent, such as an officer of the company sign it, so long as we indicate in the form who the resident agent is?

Answer: The Bid/Proposal Affidavit (Attachment B) is to be signed by an authorized representative, such as an officer, of the company. In section K. (1) of the Bid/Proposal Affidavit, you must indicate the name and address of your company's resident agent.

122. Utilization & Cost Schedule - Can you please confirm what you mean by Discounted Charges or Value of Services? Should Retirees be broken out Over/Under 65?

Answer: In Attachment J-1a: Utilization and Cost Schedule, the Discounted Charges or Value of Services refers to the cost of a particular service after discount, based on rates for the service negotiated with providers, or in a capitated program, the value of the service if it had been reimbursed on a fee-for-service basis. It is not the amount paid for eligible services, therefore, it is before plan design (copays, deductibles and coinsurance) is taken into account. Data for retirees does not need to be separated by over and under 65. Please remember Attachment J-1 is for illustrative purposes only.

123. For the United Concordia DPOS plan - can you get claims broken out by Preventive, Basic, and Major? Can you get the claims broken out by In-Network and Out-of-Network Utilization?

Answer: Claims by procedure category are not available. The in-network utilization for the DPOS plan is approximately 75%.

124. Do the current carriers have performance guarantees on the current plans?

Answer: Yes, there are performance guarantees in place for the current dental vendors and plans.

125. As you know, the State is requesting that we run network analysis against your dental enrollment two ways. However, "Attachment L6: DPPO, DHMO access" provides only one chart for DPPO access where we will actually need two charts to complete the analysis properly - one chart using the current dental enrollees and the other chart using total population. Can you please provide another chart or do you prefer that we only complete one chart and if so, for which census.

Answer: Attachment L-6 includes two tables. Please provide the access results for *1) all employees and retirees currently enrolled* in the table labeled DPPO Access. Provide the access results for *2) all employees and retirees (entire census population)* in the table labeled DHMO Access. You are required to run access reports in these two ways.

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State of Maryland Department of Budget and Management
Dental Plan Benefits RFP (HMO & PPO)
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Q&A Set #4

126. The experience of the last two years broken out by each procedure by each plan currently available and the experience for the last two years by service category for each plan.

Answer: Claims by procedure or service category are not available.

64. Does the state apply the premium tax?

Replace the answer to Question #64 in Q&A Release #2 from:

Answer: ~~Premium taxes are owed to the Maryland Insurance Administration in accordance with Maryland Annotated Code, Insurance Article Title 6, Subtitle 1 and Code of Maryland Regulations, Title 31, Subtitle 6. Dental plans are generally subject to these taxation requirements unless the specific plan is exempted from taxation pursuant to Md. Ann. Code, Ins. Art. 6-101. For example, health maintenance organizations authorized by Title 19, Subtitle 7 of the Health-General Article are exempt from payment of the premium tax. Each Contractor is responsible for fulfilling its obligations and responsibilities to the Maryland Insurance Administration, including the payment of taxes and filing of related tax reports where applicable.~~
to:

Answer: Premium taxes are owed to the Maryland Insurance Administration in accordance with Maryland Annotated Code, Insurance Article Title 6, Subtitle 1 and Code of Maryland Regulations, Title 31, Subtitle 6. Dental plans are generally subject to these taxation requirements unless the specific plan is exempted from taxation pursuant to Md. Ann. Code, Ins. Art. 6-101. For example, a non-profit health service plan licensed under Insurance Code, Title 14, are exempt from taxation. Each Contractor is responsible for fulfilling its obligations and responsibilities to the Maryland Insurance Administration, including the payment of taxes and filing of related tax reports where applicable.